Waterman, Robert - WHD

From: Abda Mendez <abda.mendez@lexitaslegal.com>
Sent: Thursday, October 03, 2019 11:35 AM
To: WHDPRAComments
Cc: Yalanda Holtz
Subject: Control Number 1235-0003 - Wage and Hour, U.S. Department of Labor - FMLA Proposed Forms from Deposition Solutions LLC, d/b/a Lexitas
Attachments: WH-380-F - Proposed (Lexitas).pdf; WH-382 Proposed (Lexitas).pdf

Good Morning,

Thank you so much for giving us (the employers) the opportunity to submit our comments. I have attached the FMLA Proposed forms from Deposition Solutions LLC, d/b/a Lexitas. In each attachment you will find the proposed questions or information that we wish to add in red. Please see below for more information:

Form WH380-F:

1. Page 3: Can you please add the following information above the Employee Name?
   - I Certify that the information I have provided is true and correct.
   - Add the date option next to the name.

Form WH382:

1. Section II: Incomplete or Insufficient Certification. Can you please add the following option?
   - Due to not receiving the Medical Certification form as requested with-in the 15-day period/deadline.
2. Section III: FMLA Leave Approved, number (2) and (3) can we please add the following option?
   - ___PTO hours available to use ___Personal/Sick hours available to use

Abda Mendez

Human Resources Coordinator
346-444-8918/ Direct
281-469-5580/ Main Ext. 1131
888-893-3767 / Reporting
800-497-7618 / Records

LEXITAS

The Letter of the Law. The Spirit of Service.

Certification of Health Care Provider for Serious Health Condition of the Family Member
(Family and Medical Leave Act)
U.S. Department of Labor
Wage and Hour Division

RETURN TO THE PATIENT - DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.

OMB Control Number: 1235-0003
Expires: xx/xx/20xx

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 C.F.R. § 825.305. If requested by the employer, the medical certification is required for the leave to be FMLA-protected. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days**, absent unusual circumstances, to provide the certification. If the employee is unable to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

SECTION I - EMPLOYER

Please complete this section before giving this form to your employee.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____
(List date certification requested from the employee)

(3) On _____ *(date)*, we learned of your need for leave beginning on _____ *(date)* for the health condition of your family member.

(4) The medical certification must be returned by _____, absent unusual circumstances.
(*List date the certification is due, which must be at least 15 days from the date the certification is given to the employee*)

SECTION I - EMPLOYER INSTRUCTIONS

Please complete Section I before giving this form to your employee. Your response is voluntary. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308**. Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employee Name: _____

SECTION II - EMPLOYEE

The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days, absent unusual circumstances.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

Please complete and sign Section II before giving this form to your family member or his/her health care provider.

(1) Name of the family member for whom you will provide care:

_____

(2a) Identify the relationship of the family member to you:
(Select as appropriate)

- ☐ Spouse
- ☐ Parent, including *in loco parentis*
- ☐ Child, including *in loco parentis*

(*In loco parentis* refers to a relationship in which a person assumes the obligations of a parent to a child. This means that an employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent.)

(2b) If the family member is your son or daughter, provide the date of birth: _____

(3a) Briefly describe the care you will provide to your family member:
(Select as appropriate)

- ☐ Assistance with basic medical, hygienic, nutritional, or safety needs
- ☐ Transportation
- ☐ Physical Care
- ☐ Psychological Comfort
- ☐ Other: _____

(3b) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(4) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced work schedule you need:

Starting date _____ Ending date _____
Hour(s) per day _____ Day(s) per week _____

Employee Signature _____ ***Date*** _____

I Certify that the information I have provided is true and correct.

Employee Name: _____ Date: _____

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. See page 4 for additional instructions.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

E-mail address: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Several questions seek a response as to the amount of time, as it relates to how often (the frequency) or how long (the duration) is needed for treatment, care, related incapacity, and/or recovery of a serious health condition of the patient. Be as specific as you can; terms such as "*lifetime*," "*unknown*," or "*indeterminate*" may not be sufficient to determine if the benefits and protections of the FMLA apply.

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

_____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g.*, assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort). _____

_____

For the questions below, check the box indicating appropriate medical information.

(Select the appropriate category – see page 6 for definitions of these terms)

☐ (5a) Inpatient Care

The patient ☐ has been / ☐ is expected to be admitted for **an overnight stay** in a hospital, hospice, or residential medical care facility. List the date(s) of admission:

_____

_____

(5b) **Beyond the overnight stay**, the patient ☐ has been / ☐ is expected to be incapacitated from

_____ to _____

Employee Name: _____

☐ (6a) Incapacity Plus Treatment
The patient ☐ has been / ☐ will be **incapacitated** from
_____ to _____
due to his/her medical condition.

(6b) Due to the condition, the patient ☐ was / ☐ will be seen on the following date(s):

_____

_____

(6c) Medication, other than over-the-counter medication, ☐ has been / ☐ will be prescribed.

☐ (7) Pregnancy
The condition is **pregnancy**. State the expected delivery date: _____

☐ (8) Chronic Conditions
Due to the condition, it is medically necessary for the patient to have **treatment visits at least twice per year**.

☐ (9) Permanent or Long Term Conditions *(e.g., Alzheimer's disease, the terminal stages of cancer)*
Due to the condition, incapacity is **permanent or long term** and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ (10) Conditions Requiring Multiple Treatments (*e.g., chemotherapy, restorative surgery after an accident)* Due to the condition, it is medically necessary for the patient to receive **multiple treatments** on: _____

_____

(11) Briefly describe other appropriate medical facts, if any, related to the condition of the patient for which the employee seeks FMLA leave. _____

_____

PART B: Amount of Leave Needed

Provide your best estimate of the amount of additional leave, not otherwise captured in Part A, needed for treatment, care, and/or recovery of the patient.

(Select as appropriate)

☐ (1) Due to the condition, the patient ☐ was / ☐ will be **incapacitated for a continuous period of time** due to his/her medical condition, including any time for treatment and recovery. Estimate the beginning and end date for the period of incapacity: _____

_____

☐ (2) Due to the condition, the patient ☐ had / ☐ will have **planned medical treatment(s)** on: *(e.g., prenatal appointments)* _____

_____

Employee Name: _____

☐ (3a) Due to the condition, the patient ☐ was / ☐ will be **referred to other health care provider(s)** for evaluation or treatment. State the nature of such treatments: *(e.g., physical therapy)*

_____

_____

(3b) Provide your **best estimate** of the duration of the treatment(s), including any recovery period:

_____

_____

☐ (4) Due to the condition, the patient ☐ required / ☐ requires / ☐ will require care on an **intermittent basis** (periodically), including for any foreseeable or unforeseeable episodes of incapacity *(i.e., episodic flare-ups)*.

Provide your **best estimate** of how long (the duration) and how often (the frequency) the intermittent episode(s) will last *(e.g., 2 hours each episode, 1 time per week)*.

Amount of Time (Duration)	**How Often (Frequency)**
_____ Hour(s)	_____ Per Day
_____ Day(s)	_____ Per Week
_____ Week(s)	_____ Per Month
_____ Month(s)	_____ Per Year

Signature of Health Care Provider _____ **Date** _____

SECTION III - HEALTH CARE PROVIDER INSTRUCTIONS

A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. 29 C.F.R. §§ 825.305-825.306. If the employer requests medical certification, the employee is responsible for providing a complete and sufficient certification, generally **at least 15 calendar days** after the employer's request. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment.

Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

The chart below provides the definition of a serious health condition under the FMLA.

Definition of a Serious Health Condition
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments • Restorative surgery after an accident or other injury; or, • A condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the employee or employee's family member did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

RETURN TO THE PATIENT - DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.

Designation Notice
(Family and Medical Leave Act)
U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

RETURN TO THE EMPLOYEE – DO NOT SEND TO THE DEPARTMENT OF LABOR

OMB Control Number: 1235-0003
Expires: x/xx/20xx

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

SECTION I - EMPLOYER

Date: _____ From: _____
(Employer)

To: _____
(Employee)

On _____ *(date)* we received your most recent information to support your need for leave due to:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child
- ☐ Your own serious health condition
- ☐ The serious health condition of your spouse, child, or parent
- ☐ A qualifying exigency arising out of the fact that your spouse, son, daughter or parent is on covered active duty or has been notified of an impending call or order to covered active duty with the Armed Forces
- ☐ A serious injury or illness of a covered servicemember where you are the servicemember's spouse, child, parent, or next of kin *(Military Caregiver Leave)*

We have reviewed information related to your need for leave under the FMLA along with any supporting documentation provided and decided: ***(Select as appropriate)***

☐ Your FMLA leave request is **Approved.** All leave taken for this reason will be designated as FMLA leave.
See Section III below for information.

☐ Your FMLA Leave request is **Not Approved**: ***(Select as appropriate)***
- ☐ The FMLA does not apply to your leave request.
- ☐ As of the date the leave is to start, you do not have any FMLA leave available to use.
- ☐ Other _____

☐ **Additional information** is needed to determine if your leave request qualifies as FMLA leave. ***See Section II below for specific information needed.***

Employee Name: _____

SECTION II – ADDITIONAL INFORMATION NEEDED

We are requesting additional information to determine whether your leave request qualifies under the FMLA. Once we obtain the additional information requested, we will inform you **within 5 business days** if your leave will or will not be designated as FMLA leave and count towards the amount of FMLA leave you have available. **Failure to provide the additional information as requested may result in a denial of your FMLA leave request**.

If you have any questions, please contact:

_____ at _____.
(Name of employer FMLA representative) *(Contact information)*

Incomplete or Insufficient Certification

The certification you have provided is incomplete and / or insufficient to determine whether the FMLA applies to your leave request.

☐ The certification provided is incomplete and we are unable to determine whether the FMLA applies to your leave request. *"Incomplete" means one or more of the applicable entries on the certification have not been completed.*

☐ The certification provided is insufficient to determine whether the FMLA applies to your leave request. *"Insufficient" means the information provided is vague, unclear, ambiguous or non-responsive.*

Specify information needed to make the certification complete and / or sufficient:

_____

_____

_____

- Due to we did not received the medical certification form as requested with-in the 15-days period/deadline.

You must provide the requested information no later than _____ *(List date due, provide at least seven calendar days)*, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

Second and Third Opinions

☐ We request that you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time. *Note: The employee or the employee's family member may be requested to authorize his or her health care provider to release information pertaining only to the serious health condition at issue.*

Employee Name: _____

SECTION III – FMLA LEAVE APPROVED

As explained in Section I, your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave and will count against the amount of FMLA leave you have available to use in the applicable 12-month period. The FMLA requires that you notify us as soon as practicable if the dates of scheduled leave change, are extended, or were initially unknown.

Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against the total **amount of FMLA leave** you have available to use in the applicable 12-month period:

(Select as appropriate)

☐ Provided there is no deviation from your **anticipated FMLA leave schedule**, the following number of hours, days or weeks will be counted against your leave entitlement:

_____

_____

☐ Because the leave you will need will be **unscheduled**; it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised: ***(check if applicable)***

☐ (1) **You will not be paid during your FMLA leave.**
Any unpaid FMLA leave taken will count against the amount of FMLA leave you have available to use.

☐ (2) **Based on your request, you are substituting or using paid leave during your FMLA leave.**
(E.g., sick leave, vacation pay, PTO)
Any paid leave taken for this reason will count against the amount of FMLA leave you have available to use.
___ PTO hours available to use ___ Personal/Sick hours available to use

☐ (3) **We are requiring you to substitute or use paid leave during your FMLA leave.**
(E.g., sick leave, vacation pay, PTO)
Any paid leave taken for this reason, will count against the amount of FMLA leave you have available to use.
___ PTO hours available to use___ Personal/Sick hours available to use

☐ (4) **Your FMLA leave will be used at the same time with other types of paid leaves or benefits.**
(E.g. short or long-term disability, workers' compensation, state medical leave law)
Any paid leave or benefit taken for this reason will count against the amount of FMLA leave you have available to use.

Employee Name: _____

☐ (5) **Return-to-work requirements.**

To be restored to work after taking FMLA leave, you will be required to provide a certification from your health care provider (fitness-for-duty certification) that you are able to resume work. This request for a fitness-for-duty certification is *only* with regard to the particular serious health condition that caused your need for FMLA leave. **If such certification is not ~~timely~~ received, your return to work may be delayed until the certification is provided.** by _____(date)

A list of the essential functions of your position:

☐ **is attached.** If attached, the fitness-for-duty certification must address your ability to perform these functions.

☐ **is not attached.**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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